Uniform Medicaid and Uninsured Uncompensated Care Cost and Charge Report (UCCR)

Hospital:	
Medicare Provider Number:	
Reporting Period From:	
Reporting Period To:	
UCCR Version:	

Contact Information

Contact Person for this report:	
Contact Title:	
Contact Email:	
Contact Phone Number:	

Filing Date:	

Is the amount of the HSN assessment included as a cost in the CMS-2552 used to complete this report?	
If yes, please report the amount here:	

SCHEDULE A: MASSHEALTH FEE-FOR-SERVICE (FFS) COSTS

FILING DATE: 1/0/1900

UCCR Version (Interim/Final): 0

COMPUTATION OF MASSHEALTH FEE-FOR-SERVICE COSTS

PROVIDER NAME: 0

PROVIDER NUMBER: 0 REPORTING PERIOD: FROM: 1/0/1900

TO: 1/0/1900

Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	OBSERVATION COST RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90) (2)	TOTAL COSTS (COL 1 + COL 2) (3)	CHARGES (FROM 2552 WKSHT C PART I COL 8) (4)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4) (5)	MASSHEALTH FFS INPATIENT CHARGES (6)	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46) (7)	MASSHEALTH FFS OUTPATIENT CHARGES (8)	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8) (9)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0	0
31	Intensive Care Unit			0		0.000		0		0	0
32	Coronary Care Unit			0		0.000		0		0	0
33	Burn Intensive Care Unit			0		0.000		0		0	0
34	Surgical Intensive Care Unit			0		0.000		0		0	0
35	Other Special Care (specify)			0		0.000		0		0	0
40	Subprovider IPF			0		0.000		0		0	0
41	Subprovider IRF			0		0.000		0		0	0
42	Subprovider (specify)			0		0.000		0		0	0
43	Nursery			0		0.000		0		0	0
44	Skilled Nursing Facility			0		0.000		0		0	0
45	Nursing Facility			0		0.000		0		0	0
46	Other Long Term Care			0		0.000		0		0	0
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room			0		0.000		0		0	0
51	Recovery Room			0		0.000		0		0	0
52	Labor Room and Delivery Room			0		0.000		0		0	0
53	Anesthesiology			0		0.000		0		0	0
54	Radiology-Diagnostic			0		0.000		0		0	0
55	Radiology-Therapeutic			0		0.000		0		0	0
56	Radioisotope			0		0.000		0		0	0
57	Computed Tomography (CT) Scan			0		0.000		0		0	0
58	Magnetic Resonance Imaging (MRI)			0		0.000		0		0	0
59	Cardiac Catheterization			0		0.000		0		0	0
60	Laboratory			0		0.000		0		0	0
61	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0	0
62	Whole Blood & Packed Red Blood Cells			0		0.000		0		0	0
63	Blood Storing, Processing, & Trans.			0		0.000		0		0	0
64	Intravenous Therapy			0		0.000		0		0	0
65	Respiratory Therapy			0		0.000		0		0	0
66	Physical Therapy			0		0.000		0		0	0
67	Occupational Therapy			0		0.000		0		0	0
68	Speech Pathology			0		0.000		0		0	0
69	Electrocardiology			0		0.000		0		0	0
70	Electroencephalography			0		0.000		0		0	0
71	Medical Supplies Charged to Patients			0		0.000		0		0	0
72	Implantable Devices Charged to Patients			0		0.000		0		0	0
73	Drugs Charged to Patients			0		0.000		0		0	0
74	Renal Dialysis			0		0.000		0		0	0
75	ASC (Non-Distinct Part)			0		0.000		0		0	0
76	Other Ancillary (specify)			0		0.000		0		0	0
	OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic			0		0.000		0		0	0

SCHEDULE A: MASSHEALTH FEE-FOR-SERVICE (FFS) COSTS

FILING DATE: 1/0/1900

UCCR Version (Interim/Final): 0

COMPUTATION OF MASSHEALTH FEE-FOR-SERVICE COSTS

PROVIDER NAME: 0

PROVIDER NUMBER: 0 REPORTING PERIOD: FROM: 1/0/1900

TO: 1/0/1900

Ln No.	COST CENTER DESCRIPTION	COSTS INCLUDING INTERNS & RESIDENTS (FROM 2552 WKSHT B PART I COL 24) (1)	OBSERVATION COST RECLASS (LINE 30 TO LINE 92) AND POST STEPDOWN COSTS (FROM WKSHT B -2 COL 4 LINES 54, 60, 89 & 90) (2)	TOTAL COSTS (COL 1 + COL 2) (3)	CHARGES (FROM 2552 WKSHT C PART I COL 8) (4)	HOSPITAL COST TO CHARGE RATIOS (COL 3 / COL 4) (5)	MASSHEALTH FFS INPATIENT CHARGES (6)	MASSHEALTH FFS I/P COSTS (COL 5 x COL 6 except lines 30-46) (7)	MASSHEALTH FFS OUTPATIENT CHARGES (8)	MASSHEALTH FFS O/P COSTS (COL 5 x COL 8) (9)	TOTAL MASSHEALTH. FFS I/P AND O/P COSTS (COL 7 + COL 9) (10)
	INPATIENT ROUTINE SERVICE COST CENTERS										
89	Federally Qualified Health Center			0		0.000		0		0	0
90	Clinic			0		0.000		0		0	0
91	Emergency			0		0.000		0		0	0
92	Observation Beds (see instructions)			0		0.000		0		0	0
93	Other Outpatient Service (specify)			0		0.000		0		0	0
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis			0		0.000		0		0	0
95	Ambulance Services			0		0.000		0		0	0
96	Durable Medical Equipment-Rented			0		0.000		0		0	0
97	Durable Medical Equipment-Sold			0		0.000		0		0	0
98	Other Reimbursable (specify)			0		0.000		0		0	0
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0	0
101	Home Health Agency			0		0.000		0		0	0
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition			0		0.000		0		0	0
106	Heart Acquisition			0		0.000		0		0	0
107	Liver Acquisition			0		0.000		0		0	0
108	Lung Acquisition			0		0.000		0		0	0
109	Pancreas Acquisition			0		0.000		0		0	0
110	Intestinal Acquisition			0		0.000		0		0	0
111	Islet Acquisition			0		0.000		0		0	0
112	Other Organ Acquisition (specify)			0		0.000		0		0	0
115	Ambulatory Surgical Center (Distinct Part)			0		0.000		0		0	0
116	Hospice			0		0.000		0		0	0
117	Other Special Purpose (specify)			0		0.000		0		0	0
118	**SUBTOTAL (sum of lines 30-117)**	0	0	0	0		0	0	0	0	0
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										
191	Research										
192	Physicians' Private Offices										
193	Nonpaid Workers										
194	Other Nonreimbursable (specify)										
200	Cross Foot Adjustments										
201	Negative Cost Centers										

SCHEDULE B: ROUTINE COST CENTER PER DIEMS

FILING DATE: 1/0/1900

UCCR Version (Interim/Final): 0

COMPUTATION OF ROUTINE COST CENTER PER DIEMS

PROVIDER NAME: 0

PROVIDER NUMBER: 0 FROM: 1/0/1900

TO: 1/0/1900

Ln No.	COST CENTER DESCRIPTION	TOTAL COSTS (COL 3 OF SCHEDULE A) (1)	TOTAL PATIENT DAYS (WS S -3 PART I COL 8) (2)	PER DIEM (COL 1 / COL 2) (3)	FFS PATIENT DAYS (4)	FFS INPATIENT COSTS (COL 3 x COL 4) (5)	MMCO PATIENT DAYS (6)	MMCO INPATIENT COSTS (COL 3 x COL 6) (7)	HSN & UNINSURED CARE PATIENT DAYS (8)	HSN & UNINSURED CARE INPATIENT COSTS (COL 3 x COL 8) (9)	DUAL-ELIGIBLE PATIENT DAYS (10)	DUAL-ELIGIBLE INPATIENT COSTS (COL 3 x COL 10) (11)
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	0		0.00		0		0		0		0
31	Intensive Care Unit	0		0.00		0		0		0		0
32	Coronary Care Unit	0		0.00		0		0		0		0
33	Burn Intensive Care Unit	0		0.00		0		0		0		0
34	Surgical Intensive Care Unit	0		0.00		0		0		0		0
35	Other Special Care (specify)	0		0.00		0		0		0		0
40	Subprovider IPF	0		0.00		0		0		0		0
41	Subprovider IRF	0		0.00		0		0		0		0
42	Subprovider (specify)	0		0.00		0		0		0		0
43	Nursery	0		0.00		0		0		0		0
44	Skilled Nursing Facility	0		0.00		0		0		0		0
45	Nursing Facility	0		0.00		0		0		0		0
46	Other Long Term Care	0		0.00		0		0		0		0
	TOTAL PATIENT DAYS		0		0		0		0		0	

SCHEDULE C: MEDICAID MCO (MMCO), HSN & UNINSURED & DUAL-ELIGIBLE COSTS

COMPUTATION OF MASSACHUSETTS MEDICAID MCO AND LOW INCOME UNCOMPENSATED CARE COSTS

Ln No.	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS (SCH A COL 5) (1)	MASS. MMCO INPATIENT CHARGES (2)	MASS. MMCO INPATIENT COSTS (COL 1 x COL 2 except lines 30 - 46) (3)	MASS. MMCO OUTPATIENT CHARGES (4)	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4) (5)	TOTAL MASS. MMCO I/P AND O/P COSTS (COL 3 + COL 5) (6)	HSN & UNINSURED CARE INPATIENT CHARGES (7)	HSN & UNINSURED INPATIENT COSTS (COL 1 x COL 7 except lines 30 - 46) (8)	HSN & UNINSURED CARE OUTPATIENT CHARGES (9)	HSN & UNINSURED CARE OUTPATIENT COSTS (COL 1 x COL 9) (10)	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10) (11)
30	Adults and Pediatrics (General Routine Care)	0.000		0		0	0		0		0	0
31	Intensive Care Unit	0.000		0		0	0		0		0	0
32	Coronary Care Unit	0.000		0		0	0		0		0	0
33	Burn Intensive Care Unit	0.000		0		0	0		0		0	0
34	Surgical Intensive Care Unit	0.000		0		0	0		0		0	0
35	Other Special Care (specify)	0.000		0		0	0		0		0	0
40	Subprovider IPF	0.000		0		0	0		0		0	0
41	Subprovider IRF	0.000		0		0	0		0		0	0
42	Subprovider (specify)	0.000		0		0	0		0		0	0
43	Nursery	0.000		0		0	0		0		0	0
44	Skilled Nursing Facility	0.000		0		0	0		0		0	0
45	Nursing Facility	0.000		0		0	0		0		0	0
46	Other Long Term Care	0.000		0		0	0		0		0	0
	ANCILLARY SERVICE COST CENTERS											
50	Operating Room	0.000		0		0	0		0		0	0
51	Recovery Room	0.000		0		0	0		0		0	0
52	Labor Room and Delivery Room	0.000		0		0	0		0		0	0
53	Anesthesiology	0.000		0		0	0		0		0	0
54	Radiology-Diagnostic	0.000		0		0	0		0		0	0
55	Radiology-Therapeutic	0.000		0		0	0		0		0	0
56	Radioisotope	0.000		0		0	0		0		0	0
57	Computed Tomography (CT) Scan	0.000		0		0	0		0		0	0
58	Magnetic Resonance Imaging (MRI)	0.000		0		0	0		0		0	0
59	Cardiac Catheterization	0.000		0		0	0		0		0	0
60	Laboratory	0.000		0		0	0		0		0	0
61	PBP Clinical Laboratory Services-Program Only	0.000		0		0	0		0		0	0
62	Whole Blood & Packed Red Blood Cells	0.000		0		0	0		0		0	0
63	Blood Storing, Processing, & Trans.	0.000		0		0	0		0		0	0
64	Intravenous Therapy	0.000		0		0	0		0		0	0
65	Respiratory Therapy	0.000		0		0	0		0		0	0
66	Physical Therapy	0.000		0		0	0		0		0	0
67	Occupational Therapy	0.000		0		0	0		0		0	0
68	Speech Pathology	0.000		0		0	0		0		0	0
69	Electrocardiology	0.000		0		0	0		0		0	0
70	Electroencephalography	0.000		0		0	0		0		0	0
71	Medical Supplies Charged to Patients	0.000		0		0	0		0		0	0
72	Implantable Devices Charged to Patients	0.000		0		0	0		0		0	0
73	Drugs Charged to Patients	0.000		0		0	0		0		0	0
74	Renal Dialysis	0.000		0		0	0		0		0	0
75	ASC (Non-Distinct Part)	0.000		0		0	0		0		0	0
76	Other Ancillary (specify)	0.000		0		0	0		0		0	0
	OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic	0.000		0		0	0		0		0	0
89	Federally Qualified Health Center	0.000		0		0	0		0		0	0
90	Clinic	0.000		0		0	0		0		0	0
91	Emergency	0.000		0		0	0		0		0	0
92	Observation Beds	0.000		0		0	0		0		0	0

SCHEDULE C: MEDICAID MCO (MMCO), HSN & UNINSURED & DUAL-ELIGIBLE COSTS

COMPUTATION OF MASSACHUSETTS MEDICAID MCO AND LOW INCOME UNCOMPENSATED CARE COSTS

Ln No.	COST CENTER DESCRIPTION	HOSPITAL COST TO CHARGE RATIOS (SCH A COL 5) (1)	MASS. MMCO INPATIENT CHARGES (2)	MASS. MMCO INPATIENT COSTS (COL 1 x COL 2 except lines 30 - 46) (3)	MASS. MMCO OUTPATIENT CHARGES (4)	MASS. MMCO OUTPATIENT COSTS (COL 1 x COL 4) (5)	TOTAL MASS. MMCO I/P AND O/P COSTS (COL 3 + COL 5) (6)	HSN & UNINSURED CARE INPATIENT CHARGES (7)	HSN & UNINSURED INPATIENT COSTS (COL 1 x COL 7 except lines 30 - 46) (8)	HSN & UNINSURED CARE OUTPATIENT CHARGES (9)	HSN & UNINSURED CARE OUTPATIENT COSTS (COL 1 x COL 9) (10)	TOTAL HSN & UNINSURED CARE COSTS (COL 8 + COL 10) (11)
93	Other Outpatient Service (specify)	0.000		0		0	0		0		0	0
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis	0.000		0		0	0		0		0	0
95	Ambulance Services	0.000		0		0	0		0		0	0
96	Durable Medical Equipment-Rented	0.000		0		0	0		0		0	0
97	Durable Medical Equipment-Sold	0.000		0		0	0		0		0	0
98	Other Reimbursable (specify)	0.000		0		0	0		0		0	0
99	Outpatient Rehabilitation Provider (specify)	0.000		0		0	0		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)	0.000		0		0	0		0		0	0
101	Home Health Agency	0.000		0		0	0		0		0	0
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition	0.000		0		0	0		0		0	0
106	Heart Acquisition	0.000		0		0	0		0		0	0
107	Liver Acquisition	0.000		0		0	0		0		0	0
108	Lung Acquisition	0.000		0		0	0		0		0	0
109	Pancreas Acquisition	0.000		0		0	0		0		0	0
110	Intestinal Acquisition	0.000		0		0	0		0		0	0
111	Islet Acquisition	0.000		0		0	0		0		0	0
112	Other Organ Acquisition (specify)	0.000		0		0	0		0		0	0
115	Ambulatory Surgical Center (Distinct Part)	0.000		0		0	0		0		0	0
116	Hospice	0.000		0		0	0		0		0	0
117	Other Special Purpose (specify)	0.000		0		0	0		0		0	0
118	**SUBTOTAL (sum of lines 30-117)**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											
191	Research											
192	Physicians' Private Offices											
193	Nonpaid Workers											
194	Other Nonreimbursable (specify)											
200	Cross Foot Adjustments											
201	Negative Cost Centers											

	SCHEDULE C: MEDICAID MCO (MMCO),				**FILING DATE:**	**1/0/1900**
		UCCR Version (Interim/Final):		**0**		
	COMPUTATION OF MASSACHUSETTS MEDICAID M	**PROVIDER NAME:**	**0**			
		PROVIDER NUMBER:	**0**		**FROM:**	**1/0/1900**
					TO:	**1/0/1900**
Ln No.	**COST CENTER DESCRIPTION**	DUAL ELIGIBLE INPATIENT CHARGES **(12)**	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46) **(13)**	DUAL ELIGIBLE OUTPATIENT CHARGES **(14)**	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14) **(15)**	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15) **(16)**
30	Adults and Pediatrics (General Routine Care)		0		0	0
31	Intensive Care Unit		0		0	0
32	Coronary Care Unit		0		0	0
33	Burn Intensive Care Unit		0		0	0
34	Surgical Intensive Care Unit		0		0	0
35	Other Special Care (specify)		0		0	0
40	Subprovider IPF		0		0	0
41	Subprovider IRF		0		0	0
42	Subprovider (specify)		0		0	0
43	Nursery		0		0	0
44	Skilled Nursing Facility		0		0	0
45	Nursing Facility		0		0	0
46	Other Long Term Care		0		0	0
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		0		0	0
51	Recovery Room		0		0	0
52	Labor Room and Delivery Room		0		0	0
53	Anesthesiology		0		0	0
54	Radiology-Diagnostic		0		0	0
55	Radiology-Therapeutic		0		0	0
56	Radioisotope		0		0	0
57	Computed Tomography (CT) Scan		0		0	0
58	Magnetic Resonance Imaging (MRI)		0		0	0
59	Cardiac Catheterization		0		0	0
60	Laboratory		0		0	0
61	PBP Clinical Laboratory Services-Program Only		0		0	0
62	Whole Blood & Packed Red Blood Cells		0		0	0
63	Blood Storing, Processing, & Trans.		0		0	0
64	Intravenous Therapy		0		0	0
65	Respiratory Therapy		0		0	0
66	Physical Therapy		0		0	0
67	Occupational Therapy		0		0	0
68	Speech Pathology		0		0	0
69	Electrocardiology		0		0	0
70	Electroencephalography		0		0	0
71	Medical Supplies Charged to Patients		0		0	0
72	Implantable Devices Charged to Patients		0		0	0
73	Drugs Charged to Patients		0		0	0
74	Renal Dialysis		0		0	0
75	ASC (Non-Distinct Part)		0		0	0
76	Other Ancillary (specify)		0		0	0
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic		0		0	0
89	Federally Qualified Health Center		0		0	0
90	Clinic		0		0	0
91	Emergency		0		0	0
92	Observation Beds		0		0	0

	SCHEDULE C: MEDICAID MCO (MMCO),				**FILING DATE:**	**1/0/1900**
			UCCR Version (Interim/Final):	**0**		
	COMPUTATION OF MASSACHUSETTS MEDICAID M	**PROVIDER NAME:**	**0**			
		PROVIDER NUMBER:	**0**		**FROM:**	**1/0/1900**
					TO:	**1/0/1900**
Ln No.	**COST CENTER DESCRIPTION**	DUAL ELIGIBLE INPATIENT CHARGES **(12)**	DUAL ELIGIBLE INPATIENT COSTS (COL 1 x COL 12 except lines 30 - 46) **(13)**	DUAL ELIGIBLE OUTPATIENT CHARGES **(14)**	DUAL ELIGIBLE OUTPATIENT COSTS (COL 1 x COL 14) **(15)**	TOTAL DUAL ELIGIBLE COSTS (COL 13 + COL 15) **(16)**
93	Other Outpatient Service (specify)		0		0	0
	OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis		0		0	0
95	Ambulance Services		0		0	0
96	Durable Medical Equipment-Rented		0		0	0
97	Durable Medical Equipment-Sold		0		0	0
98	Other Reimbursable (specify)		0		0	0
99	Outpatient Rehabilitation Provider (specify)		0		0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)		0		0	0
101	Home Health Agency		0		0	0
	SPECIAL PURPOSE COST CENTERS					
105	Kidney Acquisition		0		0	0
106	Heart Acquisition		0		0	0
107	Liver Acquisition		0		0	0
108	Lung Acquisition		0		0	0
109	Pancreas Acquisition		0		0	0
110	Intestinal Acquisition		0		0	0
111	Islet Acquisition		0		0	0
112	Other Organ Acquisition (specify)		0		0	0
115	Ambulatory Surgical Center (Distinct Part)		0		0	0
116	Hospice		0		0	0
117	Other Special Purpose (specify)		0		0	0
118	**SUBTOTAL (sum of lines 30-117)**	**0**	**0**	**0**	**0**	**0**
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop, & Canteen					
191	Research					
192	Physicians' Private Offices					
193	Nonpaid Workers					
194	Other Nonreimbursable (specify)					
200	Cross Foot Adjustments					
201	Negative Cost Centers					

SCHEDULE D: UNCOMPENSATED PHYSICIAN COSTS

UCCR Version (Interim/Final):

COMPUTATION OF UNCOMPENSATED PHYSICIAN COSTS

PROVIDER NAME:

PROVIDER NUMBER: 0

Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8-2 COL 4) (1)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8) (2)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2) (3)	TOTAL PHYSICIAN I/P AND O/P CHARGES (4)	PHYSICIAN COST-TO-CHARGE RATIO (COL 3 / COL 4) (5)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES (6)	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6) (7)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES (8)	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8) (9)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES (10)	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10) (11)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES (12)
30	Adults and Pediatrics (General Routine Care)			0		0.000		0		0		0	
31	Intensive Care Unit			0		0.000		0		0		0	
32	Coronary Care Unit			0		0.000		0		0		0	
33	Burn Intensive Care Unit			0		0.000		0		0		0	
34	Surgical Intensive Care Unit			0		0.000		0		0		0	
35	Other Special Care (specify)			0		0.000		0		0		0	
40	Subprovider IPF			0		0.000		0		0		0	
41	Subprovider IRF			0		0.000		0		0		0	
42	Subprovider (specify)			0		0.000		0		0		0	
43	Nursery			0		0.000		0		0		0	
44	Skilled Nursing Facility			0		0.000		0		0		0	
45	Nursing Facility			0		0.000		0		0		0	
46	Other Long Term Care			0		0.000		0		0		0	
	ANCILLARY SERVICE COST CENTERS												
50	Operating Room			0		0.000		0		0		0	
51	Recovery Room			0		0.000		0		0		0	
52	Labor Room and Delivery Room			0		0.000		0		0		0	
53	Anesthesiology			0		0.000		0		0		0	
54	Radiology-Diagnostic			0		0.000		0		0		0	
55	Radiology-Therapeutic			0		0.000		0		0		0	
56	Radioisotope			0		0.000		0		0		0	
57	Computed Tomography (CT) Scan			0		0.000		0		0		0	
58	Magnetic Resonance Imaging (MRI)			0		0.000		0		0		0	
59	Cardiac Catheterization			0		0.000		0		0		0	
60	Laboratory			0		0.000		0		0		0	
61	PBP Clinical Laboratory Services-Program Only			0		0.000		0		0		0	
62	Whole Blood & Packed Red Blood Cells			0		0.000		0		0		0	
63	Blood Storing, Processing, & Trans.			0		0.000		0		0		0	
64	Intravenous Therapy			0		0.000		0		0		0	
65	Respiratory Therapy			0		0.000		0		0		0	
66	Physical Therapy			0		0.000		0		0		0	
67	Occupational Therapy			0		0.000		0		0		0	
68	Speech Pathology			0		0.000		0		0		0	
69	Electrocardiology			0		0.000		0		0		0	
70	Electroencephalography			0		0.000		0		0		0	
71	Medical Supplies Charged to Patients			0		0.000		0		0		0	
72	Implantable Devices Charged to Patients			0		0.000		0		0		0	
73	Drugs Charged to Patients			0		0.000		0		0		0	
74	Renal Dialysis			0		0.000		0		0		0	
75	ASC (Non-Distinct Part)			0		0.000		0		0		0	
76	Other Ancillary (specify)			0		0.000		0		0		0	
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic			0		0.000		0		0		0	
89	Federally Qualified Health Center			0		0.000		0		0		0	
90	Clinic			0		0.000		0		0		0	
91	Emergency			0		0.000		0		0		0	
92	Observation Beds			0		0.000		0		0		0	
93	Other Outpatient Service (specify)			0		0.000		0		0		0	
	OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis			0		0.000		0		0		0	
95	Ambulance Services			0		0.000		0		0		0	
96	Durable Medical Equipment-Rented			0		0.000		0		0		0	

SCHEDULE D: UNCOMPENSATED PHYSICIAN COSTS

UCCR Version (Interim/Final):

COMPUTATION OF UNCOMPENSATED PHYSICIAN COSTS

PROVIDER NAME:

PROVIDER NUMBER: 0

Ln No.	COST CENTER DESCRIPTION	PROFESSIONAL COMPONENT OF PHYSICIAN COSTS (FROM 2552 WKSHT A-8-2 COL 4) (1)	OVERHEAD COSTS RELATED TO PHYSICIAN SERVICES IF NOT INCLUDED IN COL 1 (FROM 2552 WKSHT A-8) (2)	TOTAL PHYSICIAN COSTS (COL 1 + COL 2) (3)	TOTAL PHYSICIAN I/P AND O/P CHARGES (4)	PHYSICIAN COST-TO-CHARGE RATIO (COL 3 / COL 4) (5)	MASSHEALTH FFS I/P AND O/P PHYSICIAN CHARGES (6)	MASSHEALTH FFS I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 6) (7)	MASS. MMCO I/P AND O/P PHYSICIAN CHARGES (8)	MASS. MMCO I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 8) (9)	HSN & UNINSURED I/P AND O/P PHYSICIAN CHARGES (10)	HSN & UNINSURED I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 10) (11)	DUAL ELIGIBLE I/P AND O/P PHYSICIAN CHARGES (12)
97	Durable Medical Equipment-Sold			0		0.000		0		0		0	
98	Other Reimbursable (specify)			0		0.000		0		0		0	
99	Outpatient Rehabilitation Provider (specify)			0		0.000		0		0		0	
100	Intern-Resident Service (not appvd. tchng. prgm.)			0		0.000		0		0		0	
101	Home Health Agency			0		0.000		0		0		0	
	SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition			0		0.000		0		0		0	
106	Heart Acquisition			0		0.000		0		0		0	
107	Liver Acquisition			0		0.000		0		0		0	
108	Lung Acquisition			0		0.000		0		0		0	
109	Pancreas Acquisition			0		0.000		0		0		0	
110	Intestinal Acquisition			0		0.000		0		0		0	
111	Islet Acquisition			0		0.000		0		0		0	
112	Other Organ Acquisition (specify)			0		0.000		0		0		0	
115	Ambulatory Surgical Center (Distinct Part)			0		0.000		0		0		0	
116	Hospice			0		0.000		0		0		0	
117	Other Special Purpose (specify)			0		0.000		0		0		0	
118	**SUBTOTAL (sum of lines 30-117)**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**
	NONREIMBURSABLE COST CENTERS												
190	Gift, Flower, Coffee Shop, & Canteen												
191	Research												
192	Physicians' Private Offices												
193	Nonpaid Workers												
194	Other Nonreimbursable (specify)												
200	Cross Foot Adjustments												
201	Negative Cost Centers												

	SCHEDULE D: UNCOMPENSATED PHYSI(	**FILING DATE:**	**1/0/1900**
		0	
	COMPUTATION OF UNCOMPENSATED PHYSICIAN0		
		FROM:	**1/0/1900**
		TO:	**1/0/1900**
Ln No.	**COST CENTER DESCRIPTION**	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) **(13)**	TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 13) **(14)**
30	Adults and Pediatrics (General Routine Care)	0	0
31	Intensive Care Unit	0	0
32	Coronary Care Unit	0	0
33	Burn Intensive Care Unit	0	0
34	Surgical Intensive Care Unit	0	0
35	Other Special Care (specify)	0	0
40	Subprovider IPF	0	0
41	Subprovider IRF	0	0
42	Subprovider (specify)	0	0
43	Nursery	0	0
44	Skilled Nursing Facility	0	0
45	Nursing Facility	0	0
46	Other Long Term Care	0	0
	ANCILLARY SERVICE COST CENTERS		
50	Operating Room	0	0
51	Recovery Room	0	0
52	Labor Room and Delivery Room	0	0
53	Anesthesiology	0	0
54	Radiology-Diagnostic	0	0
55	Radiology-Therapeutic	0	0
56	Radioisotope	0	0
57	Computed Tomography (CT) Scan	0	0
58	Magnetic Resonance Imaging (MRI)	0	0
59	Cardiac Catheterization	0	0
60	Laboratory	0	0
61	PBP Clinical Laboratory Services-Program Only	0	0
62	Whole Blood & Packed Red Blood Cells	0	0
63	Blood Storing, Processing, & Trans.	0	0
64	Intravenous Therapy	0	0
65	Respiratory Therapy	0	0
66	Physical Therapy	0	0
67	Occupational Therapy	0	0
68	Speech Pathology	0	0
69	Electrocardiology	0	0
70	Electroencephalography	0	0
71	Medical Supplies Charged to Patients	0	0
72	Implantable Devices Charged to Patients	0	0
73	Drugs Charged to Patients	0	0
74	Renal Dialysis	0	0
75	ASC (Non-Distinct Part)	0	0
76	Other Ancillary (specify)	0	0
	OUTPATIENT SERVICE COST CENTERS		
88	Rural Health Clinic	0	0
89	Federally Qualified Health Center	0	0
90	Clinic	0	0
91	Emergency	0	0
92	Observation Beds	0	0
93	Other Outpatient Service (specify)	0	0
	OTHER REIMBURSABLE COST CENTERS		
94	Home Program Dialysis	0	0
95	Ambulance Services	0	0
96	Durable Medical Equipment-Rented	0	0

	SCHEDULE D: UNCOMPENSATED PHYSI(	**FILING DATE:**	**1/0/1900**
		0	
	COMPUTATION OF UNCOMPENSATED PHYSICIAN0		
		FROM:	**1/0/1900**
		TO:	**1/0/1900**
Ln No.	**COST CENTER DESCRIPTION**	DUAL ELIGIBLE I/P AND O/P PHYSICIAN COSTS (COL 5 x COL 12) **(13)**	TOTAL UCCR PHYSICIAN COSTS (COL 7 + COL 9 + COL 11 + COL 13) **(14)**
97	Durable Medical Equipment-Sold	0	0
98	Other Reimbursable (specify)	0	0
99	Outpatient Rehabilitation Provider (specify)	0	0
100	Intern-Resident Service (not appvd. tchng. prgm.)	0	0
101	Home Health Agency	0	0
	SPECIAL PURPOSE COST CENTERS		
105	Kidney Acquisition	0	0
106	Heart Acquisition	0	0
107	Liver Acquisition	0	0
108	Lung Acquisition	0	0
109	Pancreas Acquisition	0	0
110	Intestinal Acquisition	0	0
111	Islet Acquisition	0	0
112	Other Organ Acquisition (specify)	0	0
115	Ambulatory Surgical Center (Distinct Part)	0	0
116	Hospice	0	0
117	Other Special Purpose (specify)	0	0
118	**SUBTOTAL (sum of lines 30-117)**	**0**	**0**
	NONREIMBURSABLE COST CENTERS		
190	Gift, Flower, Coffee Shop, & Canteen		
191	Research		
192	Physicians' Private Offices		
193	Nonpaid Workers		
194	Other Nonreimbursable (specify)		
200	Cross Foot Adjustments		
201	Negative Cost Centers		

SCHEDULE E: SAFETY NET HEALTH CARE SYSTEM (SNHCS) EXPENDITURES

SUMMARY OF SNHCS EXPENDITURES

FILING DATE:	1/0/1900
UCCR VERSION (INTERIM/FINAL)	0
PROVIDER NAME:	0
PROVIDER NUMBER:	0
REPORTING PERIOD: FROM:	1/0/1900
TO:	1/0/1900

Ln No.	SYSTEM FINANCIAL REQUIREMENTS DESCRIPTION	TOTAL SYSTEM EXPENDITURE (1)	MEDICAID-ELIGIBLE / HSN & UNINSURED PAYER MIX PROPORTION (2)	MEDICAID / HSN & UNINSURED SHARE OF SYSTEM EXPENDITURE (COL 1 x COL 2) (3)
1				0
2				0
3				0
4				0
5				0
6				0
7				0
8				0
9				0
10				0
11				0
12				0
13				0
14				0
15				0
	TOTAL	**0**		**0**

Safety Net Care Cost Ratio #DIV/0!

Ln. No.	SYSTEM FINANCIAL REQUIREMENTS, ADDITIONAL NARRATIVE DESCRIPTION:
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

SCHEDULE F: MEDICAID AND UNINSURED REVENUE

					Filing Date:	1/0/1900		
				UCCR Version (Interim/Final):		0		
				PROVIDER NAME:	0			
				PROVIDER NUMBER:	0			
						REPORTING PERIOD:	FROM:	1/0/1900
							TO:	1/0/1900
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
Ln No.	REVENUE DESCRIPTION	MEDICAID FFS INPATIENT	MEDICAID FFS OUTPATIENT	MMCO INPATIENT	MMCO OUTPATIENT	HSN & UNINSURED (Inpatient & Outpatient)	DUAL ELIGIBLE (Inpatient & Outpatient)	TOTAL REVENUE (SUM of COL 1 through 6)
	HOSPITAL AND CLINIC REVENUE							
1	Payer Medical Claims Revenue							0
2	Payer Performance or Incentive Payments							0
3	Supplemental Payment (specify)							0
4	Supplemental Payment (specify)							0
5	Supplemental Payment (specify)							0
6	Medicare Revenue							0
7	Third Party and Self Pay Revenue							0
8	Other Revenue (specify)							0
9	**SUBTOTAL: HOSPITAL AND CLINIC (Sum Line 1-8)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	PHYSICIAN REVENUE							
10	Payer Medical Claims Revenue							0
11	Payer Performance Payment Revenue							0
12	Supplemental Payment (specify)							0
13	Medicare Revenue							0
14	Third Party and Self Pay Revenue							0
15	Other Revenue (specify)							0
16	**SUBTOTAL: PHYSICIAN (Sum Line 10-15)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
17	**TOTAL REVENUE (Line 9 + Line 16)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
18	**TOTAL COST LIMIT PROTOCOL REVENUE Line 17 - Line 11 - Line 2)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Filing Date:	**1/0/1900**		
UCCR Version		**0**	
PROVIDER NAME:	**0**		
PROVIDER NUMBER(S):	**0**		
REPORTING PERIOD:	**FROM:**	1/0/1900	
	TO:	1/0/1900	

Use this space to provide any additional information relevant to this filing: